Fentanyl Case Review Subcommittee Report

May 2024

Dedication

This report is dedicated to the memory of all the children who lost their lives as a result of fentanyl. It is a solemn reminder of the devastating impact that fentanyl can have on individuals and communities. In their honor, let us strive to raise awareness, promote education, and advocate for measures to prevent such tragic losses in the future. Together, we can work towards a safer and healthier world for all, especially our children, who deserve nothing less than our unwavering protection and care.

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Greetings,

The release of the Missouri Child Fatality Review Program (CFRP) Annual Report for 2022 has highlighted a concerning increase in child fatalities related to fentanyl. The report revealed that in 2022, 43 children lost their lives due to fentanyl or its combination with other substances. Of those, 23 were between the ages of 15 and 17, while 20 were under the age of 5. The overall number of fentanyl-related child fatalities nearly doubled, with deaths for children under the age of 5 soaring by over 500% (**Missouri Department of Social Services**).

Understanding and grappling with these statistics poses a significant challenge, particularly considering the preventable nature of these tragedies. The loss of a child to a drug-related incident is a heartbreaking occurrence that should never transpire. It is imperative that we collectively strive for improvement on both a personal and communal level. Recognizing the unique characteristics of fentanyl compared to other drugs is essential. Although fentanyl and morphine share similarities as potent synthetic opioids, fentanyl's potency far surpasses that of morphine, being 50 to 100 times stronger (**NIDA**).

After reviewing these alarming trends, we felt compelled to take immediate action to address and mitigate the significant increase in drug-related fatalities. Collaborating with the CFRP State Panel as per 13 CSR 5-2.010 4(B) regulations (**Missouri Secretary of State**), it was evident that a comprehensive analysis of these cases was imperative to identify patterns, provide insights for anticipating potential fatalities, and establish preventive strategies. To combat these issues, the Fentanyl Case Review Subcommittee was formed with the sole purpose of reviewing investigation protocols, identifying areas for improvement, and boosting safety measures. The Subcommittee is comprised of specialists from the Missouri Department of Social Services Director's Office, Children's Division, and State Technical Assistance Team, the Missouri Department of Health and Senior Services, Missouri Department of Mental Health, child advocacy groups, healthcare providers, law enforcement, and courts personnel.

Throughout the first quarter of 2024, the Subcommittee met weekly to meticulously review and have in-depth discussions about these cases. The following report reflects the diligent considerations and thoughtful recommendations from the subcommittee. It is my sincere hope that by implementing these recommendations, we can cultivate improved practices that foster safe and nurturing environments for every child in Missouri.

In Your Service,

Robert J. Knodell, Director
Missouri Department of Social Services

Special Note

The Subcommittee only had access to Children's Division (CD) records during this review, lacking the worker's perspective on the cases and the factors influencing case decisions. Understanding the worker's viewpoint is vital for enhancing insight into the decision-making process within the CD. Access to this perspective allows a deeper comprehension of the challenges and external factors impacting workers in their daily roles. This understanding not only illuminates the complexities of each case but also presents an opportunity to provide support and empowerment for workers to fulfill their duties effectively and confidently. By recognizing and addressing these aspects, we can strive towards establishing a more informed and supportive system that empowers workers to excel and positively impact the lives of the children they care for.

Executive Summary

After analyzing the 2022 Annual Report of the Missouri Child Fatality Review Program, the Subcommittee on Fentanyl Child Fatalities was established. This Subcommittee meticulously examined these cases to pinpoint any potential gaps in treatment or care associated with the notable rise in child fatalities due to fentanyl exposure. It's crucial to note that several of these recommendations have been previously suggested in various reports. Although there might be additional factors not covered in the report, the expert team of the Subcommittee raised concerns in the following fundamental areas:

- **Investigation and Safety Protocols of Children's Division** were found lacking, posing risks for vulnerable children. The Subcommittee suggested a thorough review and improvement of safety policies and practices, especially regarding potential fentanyl exposure, to safeguard all children that come to the attention of the division.

- **Behavioral Health referral and integration** is lacking between system partners. The subcommittee identified a number of gaps between systems working with this population, including child welfare, hospitals, schools and behavioral health. This lack of collaboration left families without access to services necessary for safety.

- **Utilize and expand substance use treatment programs** across the state of Missouri. The Subcommittee noted there was a lack of viable substance use treatment options across the state for these families. The circumstances ranged from lack of knowledge of the programs to lack of meaningful access to them.

- **Drug Testing** is an important part of a child abuse investigation. The Subcommittee identified a gap in the consistency, uniformity, and accessibility of drug tests across the state leaving Children's Division (CD) without a valuable tool.

- **Public Education to include Child Welfare Practitioner Training** on the dangers of fentanyl and appropriate response was highlighted as a key prevention strategy. The Subcommittee proposed increasing awareness efforts targeting both children and caregivers to promote informed decision-making and risk reduction. Multidisciplinary child welfare team members need fentanyl specific training to understand the lethality of the drug as well as to develop and understand a best practice response to investigating these cases.

Investigation and Safety Protocols of Children's Division

Overview

The Children's Division's (CD) approach to child safety lacked essential procedures, missed warning signs and left vulnerable children at risk. The Subcommittee identified issues like inadequate case assessments and families declining services, leading to case closures. Improvements in practices, engaging with parents and service providers, and early intervention can create a safer environment for children in Missouri.

> *What do we really want our processes to look like? And how do we shore this up so the ideal is happening? So that when we make a referral (to a treatment provider), Children's Division can monitor this in a longer term way while the family is going through treatment? I think, if we really looked at these things it could make a substantial improvement in how this is going and that could mean a substantial increase in safety across the board.*
>
> ***Emily Van Schenkhof, Executive Director, Children's Trust Fund***

Recommendations

- Training from experts to encourage a holistic assessment of the family, adequately identifying safety threats, accurately utilizing the safety assessment tool, and effectively articulating safety threats and unsafe situations to the juvenile office (JO).
- Training from experts on a thorough child welfare investigation to successfully ensure safety.
- Training from experts to supervisors on worker accountability, program specific policy and practice, how to have an unsafe supervisor consult effectively, and overall child safety.
- Implement statewide use of the dedicated fatality worker model. These fatality workers would only work fatalities and have centralized oversight. Evidence from St. Louis has demonstrated having a fatality worker can enhance relationships within the Multi-Disciplinary Team (MDT) and provide a valuable feedback loop regarding gaps in policy and practice through the debriefing model.
- Increased oversight and strengthening of policy and practice around Newborn Crisis Assessments (NCAs) and educational neglect reports is imperative as both types of these reports were common in the history of these cases and often poorly worked.
    - If a parent or child tests positive for fentanyl at birth, a mandatory referral to the JO should be completed for court evaluation regarding removal or providing comprehensive oversight for safety, drug treatment, and testing.

Debriefing

After a critical event, it is crucial for CD to participate in debriefing sessions. This provides an opportunity for team members to reflect on the case, share their perspectives, and learn from their experiences. Debriefing helps in processing emotions, identifying strengths and areas for improvement, and ultimately enhances the quality of services provided to children and families.

Recommendations

- CD should collaborate with the **National Partnership for Child Safety** to endorse and apply the debriefing model within the Critical Event Review Process to cultivate and strengthen a safety culture.
  - Debriefing provides an opportunity for staff members involved with the family before or during a critical incident to foster a culture of learning, reflection, and system improvement.
  - This process, which is trauma-informed, separates the human resources response from the learning and system improvement opportunities.
  - By focusing on systems-level critical event reviews, the approach moves away from individual blame and delves into the various factors and obstacles contributing to critical incidents. Conducting thorough system reviews through debriefing can lead to valuable insights and system enhancements that refine policies, practices, and ultimately enhance child safety.

Temporary Alternative Placement Agreement (TAPA)

The Subcommittee identified a need for cases involving fentanyl to be worked through a model that includes a direct link to the courts for oversight and accountability. Due to the lethality of fentanyl it is also important to make efforts to remove children out of environments in which there is potential for fentanyl exposure until the dangers can be eliminated.

Recommendations

- Pursuant to Section 210.123, RSMo (**Revisor of Missouri**) and complying with statute Temporary Alternative Placement Agreements (TAPAs) should be explored as a best practice for CD when responding to cases in which there is fentanyl involved.
  - A TAPA is a voluntary agreement between CD, a relative of the child, and the parent or guardian of the child to provide a temporary out of home placement for a child when safety cannot be assured.
  - TAPAs require a notification to the JO with or without recommendations for removal as soon as possible after the implementation of the TAPA. This ensures the courts are aware and collaborating with CD in regards to child safety.
  - Because TAPAs are voluntary, if a family is not cooperative or unwilling to enter into a TAPA, collaboration and coordination should take place with the JO regarding next steps.
  - TAPAs require a Team Decision Making (TDM) meeting to be held as well. When dealing with a TAPA due to fentanyl risks, CD should include substance use disorder (SUD) providers.
- The Subcommittee discussed at length the lack of consistency across the state in utilization and practice for TAPAs and TDMs. CD should work to bring consistency in practice to both of these models through training and policy clarification.
- Increased usage of court ordered Family Centered Services (FCS) or Informal Adjustments across the state should also occur.

Behavioral Health Referral and Integration

Overview

The Subcommittee found a significant lack of coordination and integration between the mental health system and the child welfare system. The Missouri Department of Mental Health (DMH) and CD lack an understanding of the needs, and how to get them met, of their shared population. Often, important opportunities to link families with mental health and/or substance use services were missed. There is not a robust integration or significant understanding by CD on how to refer and access services to DMH providers.

> *"What we've seen with these cases is that there is so much of this that is interdisciplinary that requires whole communities to come together and be able to come up with solutions and strong partnerships and cross collaborations."*
> ***Rachel Jones, Director of Trauma Services, Department of Mental Health***

Recommendations

- Development of a collaborative work group to work towards a comprehensive understanding within both CD and DMH regarding the intersection of these issues and how each agency can align internally and externally to better support these families.
  - This work group should consist of both policy level and local level CD and DMH members to identify gaps in departmental and interdepartmental communication to strengthen warm hand offs of families into services.
  - This work group should work towards effective communication and coordination between these departments at all levels to identify and enhance service array, ensure meaningful access, and to identify future areas of improvement.
- CD should receive training from experts on Addiction Science and on DMH services offered in their area to better understand services, recognize what services meet family needs, and how to link to services.
- Utilize Youth Behavioral Health Liaisons into the warm handoff process from CD to DMH services. Increase understanding and utilization of 988 when families experience behavioral health crisis.
  - Conduct a statewide analysis to ensure these services are accessible, timely, and sustainable to target unique needs of children and families.

Additionally, the Subcommittee identified a number of touches these families had with hospital systems for various emergencies or hospitalizations. Hospitals often missed opportunities to refer families to a number of DMH and SUD services. This was true for parents as well as older youth. Providers often have a direct link to older youth and these professionals play a crucial role in helping older youth navigate the challenges they face in a healthy manner.

> *"(To me) these cases, you can watch, through their history. There's a traumatic event for the teen, lower level neglect, mental health struggles, substance use and then we're here reviewing these tragic cases. It's painful to watch. How do we strengthen all of the different systems that touch these teens on this trajectory to be a real interception point to not get to this review?"*
> ***Haylee Musso, Child Fatality Review Program Manager, State Technical Assistance Team***

Recommendations

- Enhance the warm-hand off from the hospital to the mental health and substance use services for older youth and families. Hospitals should work to ensure this warm-hand off prior to and after discharge for these families to have a successful link to services.

Utilize and Expand Substance Use Treatment Programs

Overview

The Subcommittee found lack of referral to and utilization of existing substance use treatment programs. Additionally, substance use programming was not widespread in the state. This leads to lack of consistency in system response and differing outcomes for families across the state. Increasing substance use programming could allow more families to experience better outcomes.

Recommendations

- Expand Regional Partnership Grants (RPG's)
  - RPG's support interagency collaborations that promote increased access to SUD treatment programs and other specialized services to caregivers of children involved with the child welfare system.
  - Missouri currently has four RPG's that are operating in different areas (**National Center on Substance Abuse and Child Welfare**).
- Expand Family Treatment Court (FTC)
  - FTC is a juvenile or family court docket, for which selected abuse, neglect, and dependency cases are identified when parental substance use is a primary factor. Judges, attorneys, child protection services, and treatment personnel unite with the goal of providing safe, nurturing, and permanent homes for children while simultaneously providing parents the necessary support and services to become drug and alcohol abstinent (**Missouri Courts**).
  - Missouri currently has four FTC Programs operating within the state (**Missouri Courts**).
- Explore programs and frameworks such as Sobriety Treatment and Recovery Teams (START)
  - The START model is designed to serve families involved in the child welfare system with at least one child age 5 or younger and one parent diagnosed with a SUD. The START model was designed to recruit, engage, and retain parents in SUD treatment while keeping children safe. The goals of START are to prevent out-of-home placements, promote child safety and well-being, increase permanency for children, encourage parental SUD recovery, and improve family stability and self-sufficiency (**Title IV-E Prevention Services Clearinghouse**).
- All Missouri counties should participate in Upstream Sequential Intercept Mapping.
  - Upstream is a community-based approach that leverages judicial leadership and collaborations with child welfare agencies, state and local public agencies, community-based organizations, and community members to increase access to community-based services, prevent child maltreatment and out-of-home placement, reduce court involvement, and support strong, safe, and healthy families (**NCSC**).

Drug Testing

Overview

Establishing uniform protocols for drug testing procedures and ensuring accessibility to reliable drug testing services are essential components in assisting CD in safeguarding the welfare of children and families. Consistent and accessible drug testing protocols help in monitoring substance use, identifying potential risks, and facilitating appropriate interventions. By promoting uniformity and accessibility to drug testing, we can strengthen the protective measures in place and increase the safety of children.

Recommendations

- CD should establish a consistent drug testing policy, including when to test children and parents, to be implemented statewide. The Subcommittee understands CD currently has a Practice Alert identifying fentanyl as an additional 'ask' on the drug test, but it is important to ensure this is enshrined in policy as well as worked into contracts with providers.
    - Providers should partner with CD to ensure comprehensive drug testing of all household members, to include children, in the care environment when one presents as exposed even when the children are not showing symptoms.
- Comprehensive training for CD staff to enhance their understanding of drug testing including how to read results and how to handle drug testing refusals. Enhanced investigative skills training should alleviate the need to solely rely on a drug test as confirmation of a safety threat.
- Uniformity in drug testing statewide must be ensured. Currently, not all providers offer the same types of drug testing panels.
- Ensure access in all Missouri counties and the City of St. Louis to a physical drug testing site. Currently, there are not physical drug testing sites in every Missouri county creating barriers and impacting consistency. Mobile drug testing should be explored.

Education & Training

Overview

The Subcommittee identified a need for increased education surrounding the dangers of fentanyl to all audiences. By educating community members, partners, parents, and the public on identifying fentanyl overdose symptoms and appropriate responses, lives can be preserved. Promoting open discussions about the risks of fentanyl and the importance of seeking immediate assistance is essential. Teaching individuals about Naloxone (Narcan), a medication that can reverse opioid overdose effects, is also crucial in preventing tragedies. It is vital for an expert group, knowledgeable in this area to lead these educational campaigns to create a safer and more informed community.

Recommendations

- Public awareness campaigns to ensure everyone understands the prevalence and lethality of fentanyl as fentanyl is now detected in almost all illicit drug transactions should be ongoing.
- Everyone should have access to Narcan as well as training on how to administer it in the event of an overdose. Everyone should also understand the need for medical intervention after Narcan has been administered as well as the importance in utilizing EMS after the administration of Narcan to receive immediate lifesaving medical interventions.
- Public awareness campaigns to create awareness on the signs and symptoms of overdose in a young child.
- Parents should understand the role of social media platforms in older youth obtaining drugs.
- Narcan education tailored to older youth should include dangers of obtaining opioids through social media platforms, how to use fentanyl test strips, and parent/caregiver awareness.
- Prescribing physicians should adhere to best practice guidelines for all adult and youth patients that includes education on the dangers/risks of exposure to fentanyl, Narcan administration, fentanyl test strip use and safe storage and disposal of fentanyl.

Due to the unique challenges fentanyl poses to child safety, MDT training on how to work these cases is extremely vital. Having an MDT understanding of the lethality and the significant threat to child safety posed by fentanyl will allow for a shared understanding of the potential progressions of these cases and what needs to happen to ensure safety.

Recommendations

- Enhancing training on fentanyl and effective response strategies for MDTs, including judges, through the development of best practices on how to work fentanyl involved cases.
  - This should be in-person, high-quality training sessions led by experienced expert trainers proficient in handling these cases effectively.
  - Establishment of local community of practice or training collaborations with DMH providers, SUD providers, and traditional child welfare MDTs to share case-response models in an effort to collaborate to better support families.

Conclusion

The Fentanyl Subcommittee recognizes the dedicated efforts of CD and its partners in the child welfare system. The pivotal role of child welfare professionals is vital as they make critical decisions to safeguard families and children across Missouri. Despite the challenges they face, implementing these recommendations will improve the current practices of CD and foster stronger collaboration among child welfare stakeholders, ultimately enhancing safety measures for children statewide.

Some of these recommendations have been previously emphasized in various reports including the 2019 Task Force on Child Safety report (**Office of Child Advocate**). It is crucial to promptly act on these suggestions to enhance the support network for children and families in Missouri during their challenging times. Accountability is key to ensuring the safety of Missouri's children, leading the Subcommittee to propose the creation of an interdisciplinary committee for ongoing oversight and to ensure the implementation of the recommendations. Continuous efforts are vital in this area, with long-term, mid-term, and short-term goals and initiatives detailed in the report needing further fine-tuning for a comprehensive plan tailored to Missouri.

As Director Knodell has expressed before, if we can prevent this tragedy from happening to even one child, it will be worth it.

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Acronym Guide

CD Children's Division
CFRP Child Fatality Review Program
DMH Department of Mental Health
DSS Department of Social Services
FCS Family Centered Services
FTC Family Treatment Court
JO Juvenile Office
MDT Multi-Discplinary Team
NCA Newborn Crisis Assessment
RPG Regional Partnership Grants
START Sobriety Treatment and Recovery Teams
SUD Substance Use Disorder
TAPA Temporary Alternative Placement Agreement
TDM Team Decision Making